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	157240	A. BUILDING _____ B. WING _____	02/03/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This visit was for a home health federal recertification survey. This visit resulted in a partial extended survey. Survey date: January 31 - February 3, 2012 Facility #: IN006009 Medicaid Vendor #: 100265900A Surveyor: Ingrid Miller, PHNS, RN Skilled unduplicated census: 162 Quality Review: Joyce Elder, MSN, BSN, RN February 8, 2012 This survey was modified as the result of an IDR 3/7/12. je	G 000		
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on home visit observations, record review, document review, and interview, the agency failed to ensure the patient's rights, including respect and privacy, were honored for 2 of 6 home visit observations (Clinical records #1 and #4). Findings	G 101		2/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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1. On 2/1/12 at 8:40 AM at a home visit observation, Employee F, home health aide (HHA), was observed to give a bed bath to Patient #1. The bath failed to evidence the patient was treated with dignity and respect as evidenced by the following:

a. During the bed bath, Employee F failed to cover Patient #1 with a bath blanket as the bed bath was completed. This patient was undressed and exposed with no bed blanket or other covering for 6 minutes. The patient had a purplish tinge to his/her hands during this time frame.

b. Clinical record #1, start of care (SOC) 7/12/05, evidenced a document titled "Clinical Management Services, Inc" with the statement, "My signature reflects the receipt of the Patient Bill of Rights and Responsibilities." with the signature of Patient #1's caregiver with the date 7/12/05.

2. On 2/2/11 at 9:30 AM at a home visit observation, Employee A, HHA, was observed to give a bed bath to Patient #4. The bath failed to evidence the patient was treated with dignity and respect as evidenced by the following:

a. During the bed bath, Employee A failed to cover Patient #4's left breast area as Employee A completed the bed bath. Employee A covered the breast after the patient's caregiver walked into the patient's room.

b. Clinical record #4, SOC 8/31/11, evidenced a document with no title that stated, "My signature reflects the receipt of the Patient Bill of Rights and Responsibilities" with the

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G 101	Continued From page 2 signature of Patient #4's caregiver with the date of 8/31/11. 3. On 2/3/12 at 3:30 PM, the administrator / director of nursing indicated Employees A and F did not allow for privacy and dignity with patient #1 and #4's bed baths. 4. The agency document titled "Personal care and support - bath, bed" with a last update of 8/08 states, "Purpose: To remove waste products from the skin ... Considerations: ... 7. Protect patient from exposure and chilling ... Procedure: ... 3. Allow for privacy. 4. Take the bedspread and regular blanket off the bed ... Leaving the patient covered with the top sheet ... Provide for privacy at all times." 5. The agency document titled "Clinical Management Services, Inc. Admission Agreement Patient Rights with no date stated, "You have the right to be free from verbal, physical, and psychological abuse and to be treated with dignity and respect ... Patient Responsibilities."	G 101		
G 108	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change	G 108		2/21/12

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G 108	Continued From page 3	G 108		

is made.

This STANDARD is not met as evidenced by:
Based on clinical record review, policy review, and interview, the agency failed to ensure patients were advised in advance of discharge for 2 of 2 closed records (Clinical record #9 and #10) reviewed.

Findings

1. Clinical record #9, start of care (SOC) 9/14/10 and discharge date of 10/26/11, failed to evidence the patient was advised in advance of discharge. A document found in clinical record #1 titled "Home Health Advance Beneficiary Notice" with a form no. CMS-R-296 (10-31-12) and OMB Approval No. 0938-0781 and with no patient signature or date stated, "We, CMS [Clinical Management Services], your home health agency, are letting you know that we are discontinuing the following items and/or services: nursing one time per week and Home Health Aide two times per week because noncompliance with care plan ... By signing below, I understand that I received this notice because the home health agency decided to stop providing the items and/or services listed above. The agency's decision doesn't change my Medicare coverage or other health insurance coverage. I can't appeal to Medicare since this Home Health Agency won't provide me with any other items and/or services; however, I can try to get the items and/or services from another Home Health agency." The record failed to evidence any documentation of when the patient received the notice.

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G 108	Continued From page 4 On 2/1/12 at 12:50 PM, the director of nursing indicated the patient did not receive written notice of discharge per agency policy. 2. Clinical record #10, SOC 7/21/11 and discharge date 9/16/11, failed to evidence the patient was advised in advance of discharge. A clinical record document titled "Home Health Discharge Summary" dated 9/19/11 and faxed to the physician on 9/20/12 stated, "Discharge Reason: Noncompliance with treatment plan and Goals/needs met. Discharge condition: Supervision improved. Progress toward goals: Pt [patient] noncompliant." The record failed to evidence any documentation of when the patient was informed of the agency's decision to discharge him/her. On 2/2/12 at 2 PM, the administrator / director of nursing indicated the patient did not receive written notice of discharge per agency policy. 3. The agency policy titled "Admission Agreement Patient Rights" stated, "You have the right to be advised of any change in the plan of care, including reasonable discharge notice. You have the right to be informed of anticipated termination of service or plans for transfer of your home health care to another agency, if you refuse to comply with the plan of care and this threatens to compromise the providers commitment to quality of care."	G 108		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply	G 121		2/21/12

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G 121	Continued From page 5 to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on home visit observation, interview, and policy review, the agency failed to ensure that 2 of 6 clinical staff (Employee B and F) observed at 2 of 6 home visits (Clinical records #1 and #2) followed agency infection control policies with the potential to affect all the agency's patients. Findings 1. At a home visit observation on 2/1/12 at 8:40 AM, Employee F, a home health aide (HHA), was observed to give a bed bath to Patient #1. After donning gloves, the HHA filled and placed a basin of warm water on the bedside table. Next to the basin, the HHA placed a bar of soap. There was no barrier protecting the soap and basin on the bedside table surface. After washing the patient's face, neck, arms, chest, abdomen, legs, and feet, the HHA placed the wash cloth on the bedside table. Then the HHA dumped the used water and filled the basin with clean warm water. The HHA changed gloves without washing his/her hands and returned to the patient with the clean water. Then the HHA washed and dried the patient's back and anal area with a wash cloth and towel. The wash cloth and towel were thrown on to the floor. The peri area was not washed during this bath. 2. At a home visit observation on 2/1/12 at 10:15 AM, Employee B, a licensed practical nurse (LPN), was observed to perform one wound dressing change and a physical assessment on	G 121		

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G 121	Continued From page 6	G 121		

patient #2. During the wound dressing change, the LPN pulled off the old dressing and placed the soiled dressing into the patient's trash without double bagging the soiled dressing. After washing hands and donning clean gloves, the LPN used already opened normal saline to dip sterile 4 by 4 gauze, by dipping a sterile applicator and the gauze, and then cleansed the abdominal wound area. After packing the wound with dry gauze and applying 4 by 4 gauze, an abdominal pad was placed on top and taped in place. Gloves were removed. The LPN did not wash hands and then went through the supply bag. Next, the LPN used the stethoscope and blood pressure cuff to take vital signs. No equipment was disinfected with alcohol or other disinfectant after removing them from or returning them to the supply bag.

3. The agency policy titled "Personal Care and Support - Bath: Bed with a last update of 8/08 stated, "Purpose: To remove waste products from the skin ... Considerations: When using the soap, keep it in the soap dish ... Procedure 1. Place the basin of water on the towel ... Offer the patient a clean soap washcloth to wash his/her genital area, and then a clean wet washcloth to rinse."

4. The agency policy titled "Infection Control - Disposal / Handling of Infectious Medical Waste" with a last update of 8/08 stated, "Disposal of contaminated patient care supplies e.g. [for example]dressings, catheters, etc.[etcetera] a. Adhere to standard precautions b. place contaminated supplies in a impervious bag and close tightly. c. Double bag in a second impervious bag. A plastic trash bag lining a waste basket is acceptable. Seal second bag

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G 121	Continued From page 7 when full by tying, use of tape, or twist tie. Dispose of double-bagged waste in household trash." 5. The agency policy titled "Infection Control - Preparation of Work area and Bag Technique" with a last update of 8/08 stated, "Decontaminate hands prior to re-entering the bag for any reason. Following care: clean reusable items (blood pressure cuff, etc.) are returned to the bag." 6. On 2/3/12 at 3:40 PM, the administrator / director of nursing indicated the above visits did not follow infection control policies.	G 121		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure coordination of care occurred for 2 of 2 clinical records (Clinical record #1 and #9) reviewed of patients receiving services from other agencies. Findings 1. At a home visit observation on 2/1/12 at 8:42 AM, the caregiver for patient #1 indicated two personal assistants from Person First were hired to care for patient #1. Clinical record #1 failed to	G 144		2/21/12

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evidence the name of the agency or that staff from this agency were caring for Patient #1.

a. A home document titled "Medication Administration Month January Year 2012" listed medications taken daily by patient #1. Signatures included two personal caregivers from Person First, a private agency.

b. On 2/3/12 at 3:30 PM, the administrator / director of nursing indicated Person First personnel assisted in caring for patient #1 and the record failed to evidence the agency had coordinated care with Person First.

2. Clinical record #9 included a document titled "Patient information sheet," dated and signed by the patient on 9/6/11 that stated, "Housekeeper Tuesday and Thursday."

a. A document titled "Skilled Nursing Visit Nursing Visit Report" signed by Employee O and the patient on 10/4/11 stated, "Continue home health aide two times weekly and has housekeeper." The record failed to evidence any coordination had occurred with any other persons or agencies providing services.

b. On 2/1/12 at 1:30 PM, the administrator / director of nursing indicated patient #9 had Choice Services and Help at Home also supplying housekeeping services. There was documentation in the record to identify the agency had coordinated with these other agencies.

3. The agency policy titled "Coordination of Patient Care" stated, "Care will be coordinated with other involved external organizations, e.g.,

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G 144	Continued From page 9 home medical providers, infusion therapy / pharmacy companies and company agencies. Staff will understand agency and organizations involved in the patient's care, communicate with other individuals or organizations involved in the patient's care when significant changes occur in the patient's overall care, Share relevant information to facilitate appropriate continuity and care coordination.	G 144		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure the registered nurse coordinated care with other agencies providing services for 2 of 2 clinical records (Clinical record #1 and #9) reviewed of patients receiving services from other agencies. Findings 1. At a home visit observation on 2/1/12 at 8:42 AM, the caregiver for patient #1 indicated two personal assistants from Person First were hired to care for patient #1. Clinical record #1 failed to evidence the name of the agency or that staff from this agency were caring for Patient #1. a. A home document titled "Medication Administration Month January Year 2012" listed	G 176		2/21/12

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medications taken daily by patient #1. Signatures included two personal caregivers from Person First, a private agency.

b. On 2/3/12 at 3:30 PM, the administrator / director of nursing indicated Person First personnel assisted in caring for patient #1 and the record failed to evidence the agency had coordinated care with Person First.

2. Clinical record #9 included a document titled "Patient information sheet," dated and signed by the patient on 9/6/11 that stated, "Housekeeper Tuesday and Thursday."

a. A document titled "Skilled Nursing Visit Nursing Visit Report" signed by Employee O and the patient on 10/4/11 stated, "Continue home health aide two times weekly and has housekeeper." The record failed to evidence any coordination had occurred with any other persons or agencies providing services.

b. On 2/1/12 at 1:30 PM, the administrator / director of nursing indicated patient #9 had Choice Services and Help at Home also supplying housekeeping services. There was documentation in the record to identify the agency had coordinated with these other agencies.

3. The agency policy titled "Coordination of Patient Care" stated, "Care will be coordinated with other involved external organizations, e.g., home medical providers, infusion therapy / pharmacy companies and company agencies. Staff will understand agency and organizations involved in the patient's care, communicate with other individuals or organizations involved in the

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G 176	Continued From page 11 patient's care when significant changes occur in the patient's overall care, Share relevant information to facilitate appropriate continuity and care coordination. 4. The agency policy titled "Nursing Services" with a revision date of 2009 states, "Professional nursing service will be provided by a registered nurse and include: Coordination of services."	G 176		
G 179	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. This STANDARD is not met as evidenced by: Based on home visit observation, interview, and policy review, the agency failed to ensure the licensed practical nurse followed agency policy for 1 of 1 home visit with a licensed practical nurse (Employee B) (patient #2). Findings 1. At a home visit observation on 2/1/12 at 10:15 AM, Employee B, a licensed practical nurse (LPN), was observed to perform one wound dressing change and a physical assessment on patient #2. During the wound dressing change, the LPN pulled off the old dressing and placed the soiled dressing into the patient's trash without double bagging the soiled dressing. After washing hands and donning clean gloves, the LPN used already opened normal saline to dip sterile 4 by 4 gauze, by dipping a sterile applicator and the gauze, and then cleansed the abdominal	G 179		2/21/12

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wound area. After packing the wound with dry gauze and applying 4 by 4 gauze, an abdominal pad was placed on top and taped in place. Gloves were removed. The LPN did not wash hands and then went through the supply bag. Next, the LPN used the stethoscope and blood pressure cuff to take vital signs. No equipment was disinfected with alcohol or other disinfectant after removing them from or returning them to the supply bag.

2. The agency policy titled "Infection Control - Disposal / Handling of Infectious Medical Waste" with a last update of 8/08 stated, "Disposal of contaminated patient care supplies e.g. [for example]dressings, catheters, etc.[etcetera] a. Adhere to standard precautions b. place contaminated supplies in a impervious bag and close tightly. c. Double bag in a second impervious bag. A plastic trash bag lining a waste basket is acceptable. Seal second bag when full by tying, use of tape, or twist tie. Dispose of double-bagged waste in household trash."

3. The agency policy titled "Infection Control - Preparation of Work area and Bag Technique" with a last update of 8/08 stated, "Decontaminate hands prior to re-entering the bag for any reason. Following care: clean reusable items (blood pressure cuff, etc.) are returned to the bag."

4. On 2/3/12 at 3:40 PM, the administrator / director of nursing indicated the above visits did not follow infection control policies.